CENTER FOR SOCIAL CHANGE

We Change Lives

Center for Social Change

QUALITY ASSURANCE PLAN

JANUARY - DECEMBER 2022

ASPIRE to Excellence®

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ACCREDITED

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EXECUTIVE SUMMARY

Center for Social Change is a private, non-profit organization established in 1993. CSC provides various services for adults and children with developmental and medical disabilities throughout Maryland. Center for Social Change's main office is located in Elkridge, Maryland, and services are provided throughout Baltimore, Howard, and Anne Arundel Counties. Center for Social Change currently offers COMMUNITY HOUSING services for adults and children in assisted living, CSLA homes, ALUs, and group homes. CSC also operates an ADULT MEDICAL DAYCARE PROGRAM, EMPLOYMENT SERVICES, VOCATIONAL PROGRAMS, and DAY HABILITATION PROGRAMS.

2022 HIGHLIGHTS

Center for Social Change went through CARF accreditation for the **fourth time in 2020**. CSC was granted a 3-year accreditation for all programs, including Community Housing for adults and children, CSLA, Assisted Living, Employment, Vocational and Day Habilitation, and Adult Medical Daycare. The Board of Directors reviewed the 2022 Outcomes and progress for Center for Social Change. Center for Social Change is preparing to undergo CARF accreditation again in 2023.

PROGRAM EXPANSION

Center for Social Change currently operates **40** group homes/assisted living residences in Randallstown, Windsor Mill, and the Laurel/Savage area. At the end of the 2022 Calendar Year, 148 individuals were supported in CSC's Community Housing and Assisted Living Program. In 2022 there were 9 admissions, mainly to the Children's Program, and two discharges.

COVID-19 PANDAMEIC IMPACT

In 2022, all of our programs and services were functioning to full capacity. We have resumed all programs and activities. Our organization is still monitoring the pandemic and following our COVID protocols in case of any outbreaks. Our key actions and protocols are listed below:

CSC'S KEY ACTIONS AND PRACTICES FOR PERSONS SERVED DURING THE PANDEMIC:

- Identify and remove barriers to treatment, including ensuring accessible environments (hospitals, testing, and quarantine facilities) and the availability and dissemination of health information and communications in accessible modes, means, and formats.
- Ensuring access to technology at group homes, such as IPADs for telehealth visits.
- Ensuring the continued supply and access to medicines for persons with disabilities during the pandemic.
- Ensured ample access to PPE to staff and persons served.
- Ensured priority testing of persons with disabilities presenting symptoms.
- Ensure access to the Internet for remote learning and that software is accessible to persons with disabilities by providing assistive devices and reasonable accommodation.
- Developed accessible and adapted materials for students with disabilities to support remote learning.

COMMUNITY EDUCATION, INVOLVEMENT AND OUTREACH

In 2022, CSC continued to render services and supports in DDA's Community Pathways, Community Supports, and Family Supports programs. In addition, the following supports and services also have been approved by DDA.

- Family Peer and mentoring Supports
- Community Development Services
- Family Caregiver Training and Empowerment services
- Nursing Services (Health Case Mgmt.)
- Behavioral Support Services

CSC administration understands that as a nonprofit organization, it is vital to be engaged and relevant to the community you are located in by becoming an active member in the local area and educating the community about the needs of the person served. CSC has continued its participation (or membership) with:

- Maryland Council of Directors of Volunteer Services
- Maryland Association of Nonprofits (MANO)
- Maryland Works
- Disability Sports USA

- Liberty Road Business Association (LRBA)
- Liberty Road Community Council (LRCC)
- Fieldstone Community Association
- Maryland Chamber of Commerce
- Baltimore County Chamber of Commerce
- Howard County Commission on Disability Issues (CDI)

CSC actively participates in quarterly and annual meetings of LRBA and LRCC. CSC is an annual sponsor for the Liberty Road Tree Lighting Ceremony at the Randallstown Gateway Park. CSC continued its support even though CSC persons served could not attend the ceremony itself.

To achieve community integration for persons served, CSC arranged for persons served to enjoy multiple community activities such as a trip to Walt Disney World, Ocean City, Disney on Ice, Six flags, and various holiday parties.

STAFF EXPANSION:

CSC has demonstrated its continued commitment to developing a robust and skilled workforce to provide the highest quality standards. During the past year, 120 new direct support staff have been hired to help CSC best serve the individuals who have chosen CSC as their provider of choice.

In addition to these new hires, five new administrative staff were hired in several departments in 2022. Operations increased staff in the Medical Day Care, Day Habilitation Programs, and Community Housing Program. Currently, CSC has 399 direct care staff, 51 admin staff, one RN, and six LPNs. CSC also has contracted with outside clinical staff to provide services to individuals.

INCIDENT REPORTING

Reportable/Non-Reportable Incidents January, 2022 – December 31, 2022

Between January 1, 2022 and December 31, 2022, 152 incidents reportable with an A7 have been reported. The incidents occur with the frequency noted below for the following categories:

Reportable Incidents:

Abuse	3
Death	1
Hospital/ER	42
Hospital/Psychiatric	22

Inhumane Treatment	0
Injury	10
Other	24
Police	43
Restraint	0
Sexual Abuse	0
AWOL	5
Theft of Individual's Property or Funds	2
Total	**152**

Internally Investigated incidents:

A total of 84 internally investigated incidents occurred during the calendar year 2022; these were reported on the A5 form. A breakdown of the types, and frequency of occurrences, is shown below:

Generally, the distribution pattern of internally investigated incident types is quite similar to that found in the Reportable Incident list- that is, "Hospital visits" and "Police" visits occur with the greatest frequency in both the Reportable Incident list and the internally investigated incident list. This is, perhaps, not unexpected.

Internally Investigated incidents:

Hospital/ER/Psychiatric	51
Injury	3
Police	8
AWOL	1
Other	21
Total	84

Hospital/ER visits were the largest incident category. These visits are due to medical issues expected of the individuals involved. Examples of ER visits include seizures, wound care, g-tube care, behavioral, etc. The Standing Committee *(see Appendix B for Standing Committee details*) reviews all incidents to determine whether the responses made by staff and the agency were appropriate and whether any systemic changes need to be made to avoid such incidents in the future. The number of incidents is more significant as some are counted above for both investigated and internally investigated under both categories. However, the incident was reported by the highest level of reporting need in PCIS2.

QUALITY ASSURANCE OBJECTIVES

2023

Center for Social Change has identified the following objectives for 2023. These objectives are based on the reviews from OHCQ and suggestions from the Quality Assurance Committee.

MEDICAL /CLINICAL SERVICES

1. Maintain a 98% compliance rate to completing scheduled and referred appointments.
2. Maintain the low rate of errors for all major medication errors, at a level not to exceed 3% in any given quarter and not to exceed 5% yearly.
3. Achieve a rate of occurrence of MAR charting/ procedural errors (e.g.- Weight not documented, BP not documented, missing start dates, circles on the front not being explained on the back, medications discontinued appropriately with a reason on back of MAR) so as not to exceed 3% for any given quarter.
4. Achieve a rate of 100% of the completed consult forms to be uploaded in the THERAP on line documentation system.
5. Achieve a rate of 95% in Nursing / Health Case Management and Delegation for interim follow up evaluation after hospitalization.

PERSON CENTERED PLANS & CARE

(ADULT MEDICAL DAY, COMMUNITY HOUSING, ASSISTED LIVING, & EMPLOYMENT, DAY & VOCATIONAL SERVICES):

1. Achieve 100% of all IPs being up-to-date in Community Housing, Assisted Living, Employment Vocational & Day Habilitation Services.
2. Achieve 100% of IP implementation Within 20 days of annual IP.
3. Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare.
4. Achieve 100% of Person-Centered care plans completed for Rising Sun Assisted living units. 100% for year!
5. Achieve 100% of all MANDT Behavior support plans being reviewed and updated annually in Community Housing, Employment Vocational & Day Habilitation Services.
6. Achieve 100% of Behavior Plan implementation Within 20 days of annual IP and 100% revisions implemented within 3 days of approval by the team and Standing Committee.

HUMAN RESOURCES

1. Achieve a turnover rate of no more than 24% throughout the calendar year 2022.
2. Achieve completion rate 95% DDA-mandated/Core trainings for all staff during calendar year 2021.
3. Achieve and maintain a completion rate of 97 % performance evaluations completed

OPERATIONS/ MAINTENANCE:

1. Maintain at least a 100% rate of compliance to completion of fire and disaster drills.
2. Maintain turnaround of addressing maintenance request within 24-48 hours with 85% of completion rate.
3. Update the Maintenance database with no more than 30 days of entry missing.

TECHNOLOGY / HEALTH INFORMATION MGMT

1. Utilizing THERAP at least 80 % for all person-served demographics, and Person-Centered Plans
2. Utilizing STED 85% for ALU meetings minutes

COMMUNITY RELATION AND ADVOCACY

1. Increase family member satisfaction to at least 95%.
2. Increase Stakeholder satisfaction to at least 99%
3. Increase Staff Personnel Satisfaction to at least 90%
4. Increase at least 10% in return rate among Staff/Stakeholders and family member satisfaction survey.

QUALITY ASSURANCE REPORT 2022

CSC's Quality Assurance report covers the 2022 calendar year and focuses on the objectives that were identified in the previous year's QA Plan. In many cases, 100% of a given sample set was analyzed. However, due to a large number of program participants and available data, data for some analyses were collected utilizing randomly defined samples. Using information available in agency databases such as THERAP and STEDS, written reports, QA audits, individual files, stakeholder surveys, etc., objective data were collected and analyzed for selected program areas.

Quality Assurance Objectives for Calendar Year 2022

Medical/Clinical Services:

1. Maintain at least a 98% rate of compliance to the completion of scheduled and referred appointments.
2. Maintain the low rate of errors for all major medication errors, at a level not to exceed 3% in any given quarter and not to exceed 5% yearly.
3. Achieve a rate of occurrence of MAR charting/ procedural errors (e.g.- Weight not documented, BP not documented, missing start dates, circles on the front not being explained on the back, medications discontinued appropriately with a reason on back of MAR) so as not to exceed 3% for any given quarter.
4. Achieve a rate of 100% of the completed consult forms to be uploaded in the THERAP on line documentation system.
5. Achieve a rate of 95% in Nursing / Health Case Management and Delegation for interim follow up evaluation after hospitalization.

Person-Centered Plans & Care:

(ADULT MEDICAL DAY, COMMUNITY HOUSING, ASSISTED LIVING, & EMPLOYMENT, DAY & VOCATIONAL SERVICES):

1. Achieve 100% of all IP's being up-to-date in Community Housing, Assisted living, Employment Vocational & Day Habilitation Services.
2. Achieve 100% of IP implementation Within 20 days of annual IP.
3. Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare.
4. Achieve 100% of Person-Centered care plans completed for Rising Sun Assisted living units. 100% for year!
5. Achieve 100% of all MANDT Behavior support plans being reviewed and updated annually in Community Housing, Employment Vocational & Day Habilitation Services.

6. Achieve 100% of Behavior Plan implementation Within 20 days of annual IP and 100% revisions implemented within 3 days of approval by the team and Standing Committee.

Human Resources:

1. Achieve a turnover rate of no more than 24% throughout the calendar year 2022.
2. Achieve completion rate 95% DDA-mandated/Core trainings for all staff during calendar year 2021.
3. Achieve and maintain a completion rate of 97 % performance evaluations completed

Operations/Management:

1. Maintain at least a 100% rate of compliance to completion of fire and disaster drills.
2. Maintain turnaround of addressing maintenance request within 24-48 hours with 85% of completion rate.
3. Update the Maintenance database with no more than 30 days of entry missing.

Technology/Health Information Management:

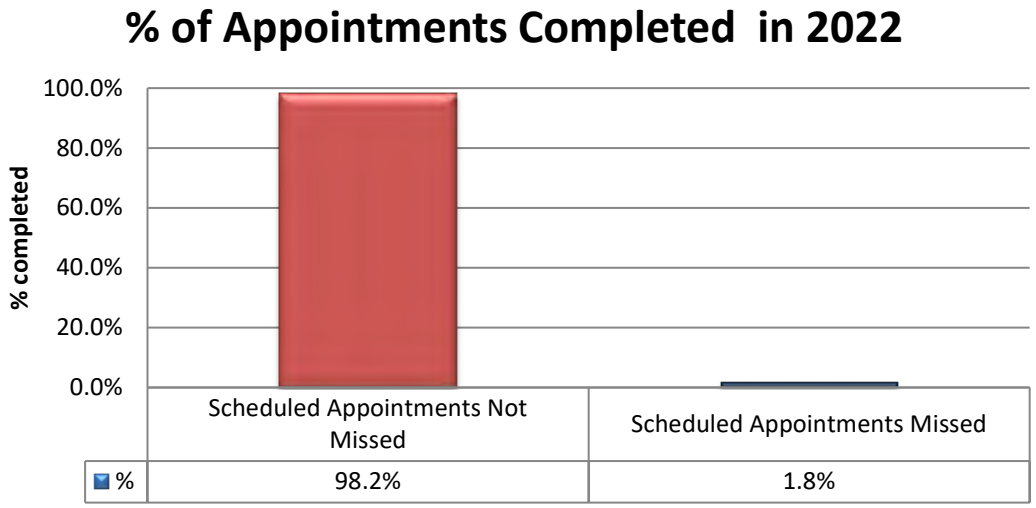
1. Utilizing THERAP at least 80 % for all person-served demographics and Person-Centered Plans
2. Utilizing STED 85% for ALU meetings minutes

Community Relations and Advocacy:

1. Increase family member satisfaction to at least 95%.
2. Increase Stakeholder satisfaction to at least 99%
3. Increase Staff Personnel Satisfaction to at least 90%
4. Increase at least 10% in return rate among Staff/Stakeholders and family member satisfaction survey.

Objective #1-a: 1. Maintain at least a 98% rate of compliance to the completion of scheduled and referred appointments. (No more than 2% will be missed)

Data was collected for each individual throughout the year by the Quality Assurance Coordinator. In total 4099 appointments were performed throughout calendar year 2022.



Summary Results/Discussion:
The results indicate that the goal of a **98.2 %** compliance rate to completion of scheduled medical appointments was met. A total of 4250 were scheduled from Jan – Dec 2022, and 79 were missed.

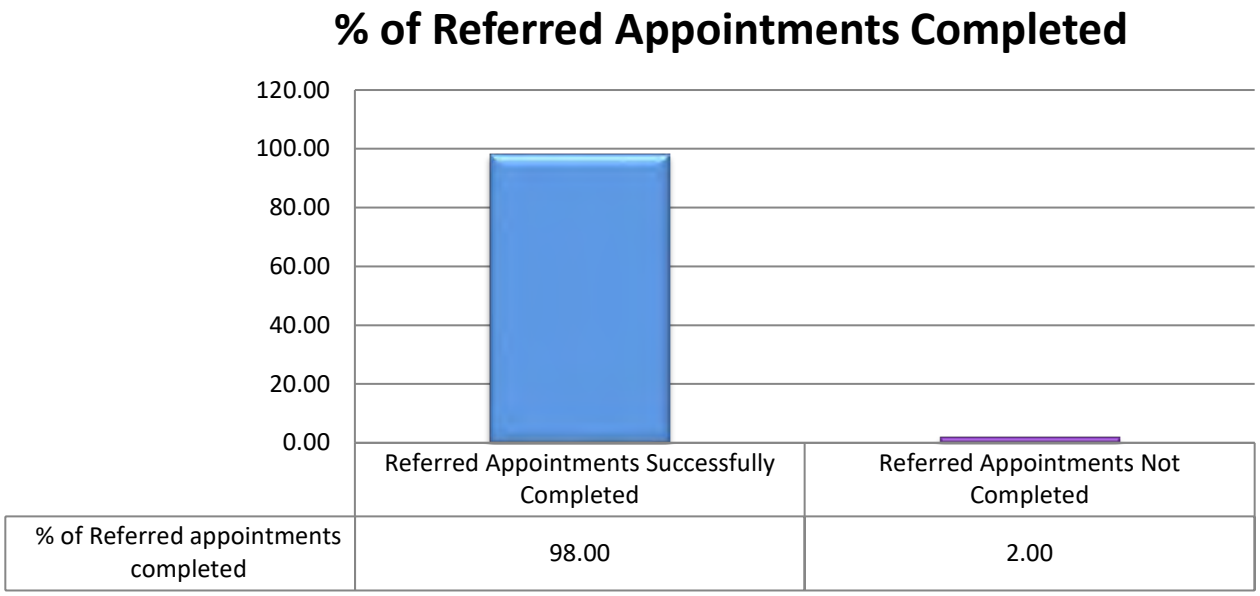
An assessment of the primary causes for which appointments were missed was completed. For those missed appointments for which a reason was identified, there were a few primary reasons that they were missed:

- Cancellations by the doctor's office
- Person Served went to the apt and refused to cooperate at the Doctor's Office.

Plan of Action:
The Coordinators who provide status reports concerning whether or not medical appointments were kept as scheduled have been informed that it is their responsibility to provide a valid reason for any appointments missed. As to why appointments are missed, the most frequently occurring reason is doctor's office cancellations, which is difficult for CSC to control. The time for all appointments will be entered into Therap, the medical scheduling database, as ½ hour before the actual appointment time. All medical appointment reports were read for each individual, and any referrals were identified. It was then further determined whether or not these referred appointments were completed.

Objective #1-b: Maintain at least a 97% compliance rate to completion of referred appointments. (No more than 3% will be missed)

Based on a review of THERAP from Jan to Dec 2022, a total of 3818 follow-up appointments were scheduled. Among those, 3798 referred appointments were completed. 90 were missed. These appointments include post–ER, dentist, endocrinology, vision, eye, hearing, and other PCP follow up. The results are demonstrated in the graph below.



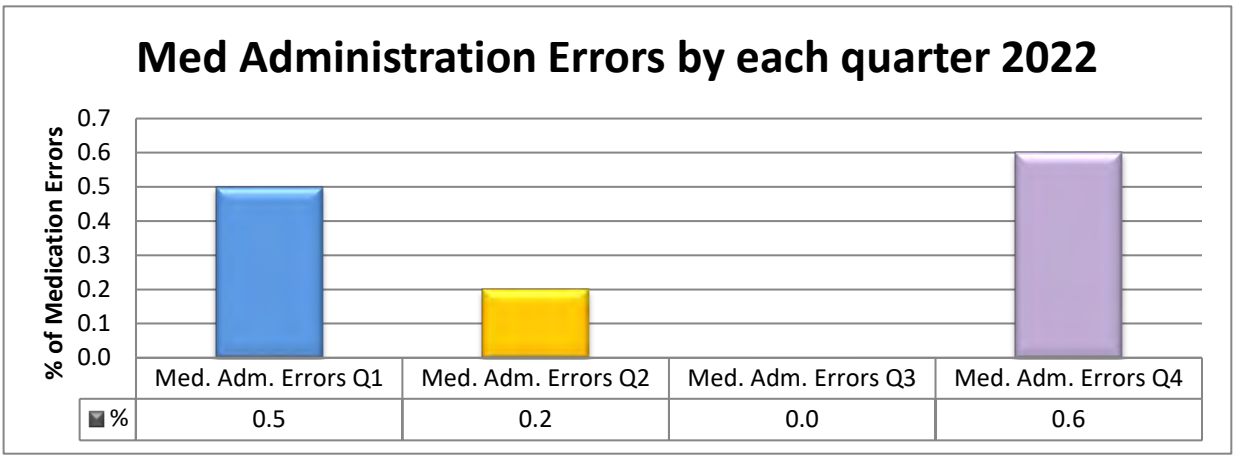
Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, 98% of appointments were completed. The results indicate that the goal of a 98% compliance rate to completion of scheduled medical appointments is met through calendar 2022. The remaining 97.36% of referred appointments were completed. The data for the follow-up appointments is as follows,

Scheduled on Therap	**4559**
Completed	3713
Missed	82
Cancelled	236
Re scheduled	273
Declined	156
Total – Otherwise Scheduled	**4559**
Total Otherwise completed	**4405**

A major reason for the small percentage of referred appointments was Doctor's office cancellations. Clinical staff dealt with the high number of rescheduled and canceled appointments as the specialty medical office was unprepared to treat patients due to a lack of staff.

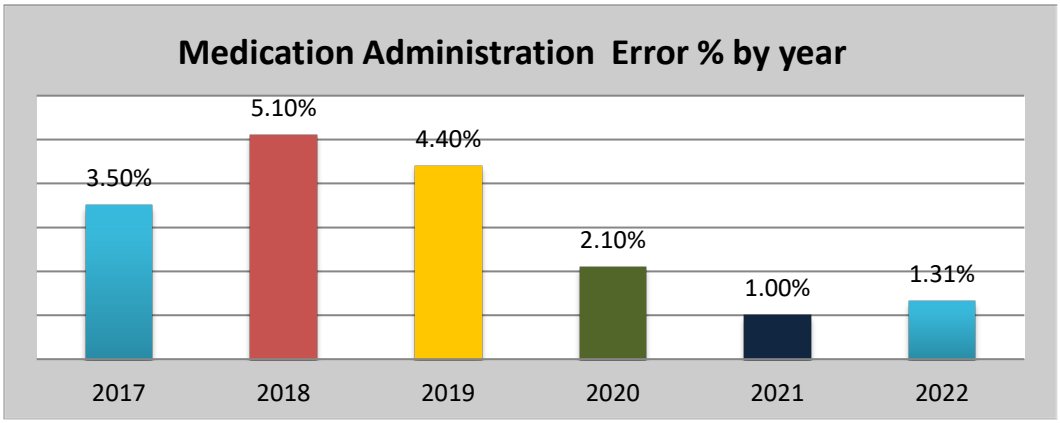
Objective #2: Maintain the low rate of major medication errors, at a level not exceeding 3% in any given quarter and not to exceed 6 % yearly.

CSC has continued its contract with Dimensional Health Care Associates for nursing delegation. As per their delegation policies, Delegating Nurses ensure proper documentation and tracking of medication errors as part of a quality assurance plan. The graph indicates the medication administration error rate for the error category "Major Errors." This error category is made of up failures by staff to give medications as prescribed. It is our goal to reach at a level not to exceed **3%** medication errors in any given quarter



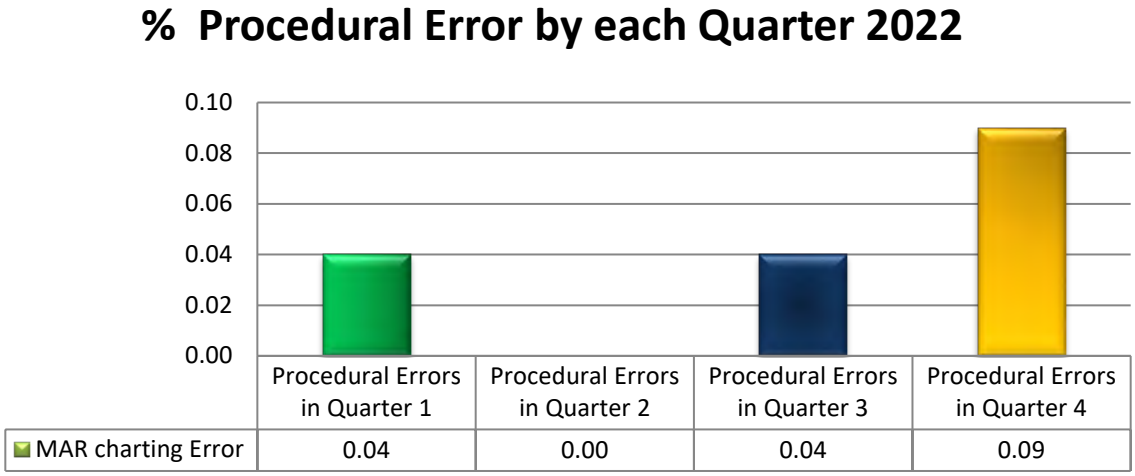
Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, the results indicate that the goal of a less than 3% error per quarter rate was met for all four quarters. The total yearly percentage for **2022 is 1.3%**. An annual comparison shows that the procedures put in place are assisting with improvements to reduce medication administration errors under a certain level. The pandemic and slower communication impacted medication errors this year.

Plan of Action:
CSC has established good quality processes and risk-management strategies to prevent medication errors. Coordinators will continue to be required to monitor medication administration at each of their daily house visits. The Quality Assurance team will continue to perform ongoing audits at a frequency of visiting each house approximately 4-5 times a month. Delegating nurses will visit the homes every 45 days. Also, Med Rite performs its reviews 4 times a month. CSC will also be monitoring the yearly percentage of medication errors not to exceed more than 6 % per year.



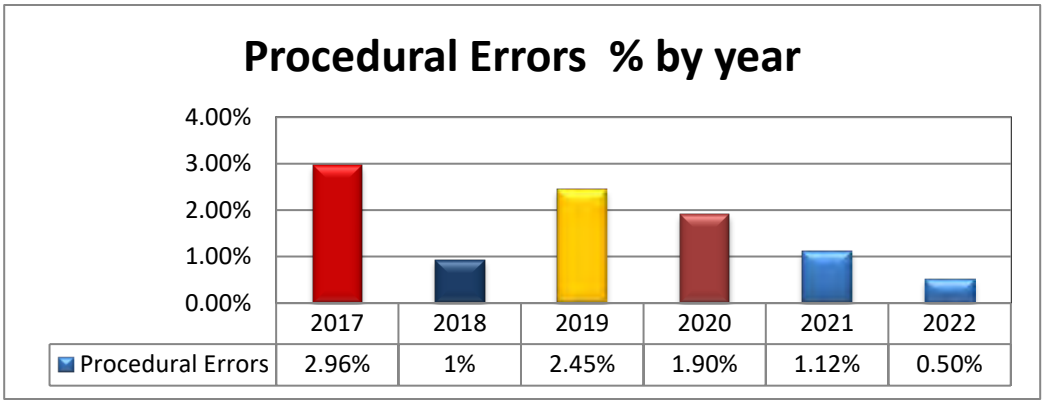
Objective 2.A: Maintain a rate of occurrence of MAR procedural errors to be at most 3% for any given quarter.

As per delegation Policies delegating nurses to ensure proper documentation and tracking of procedural errors as part of a quality assurance plan.



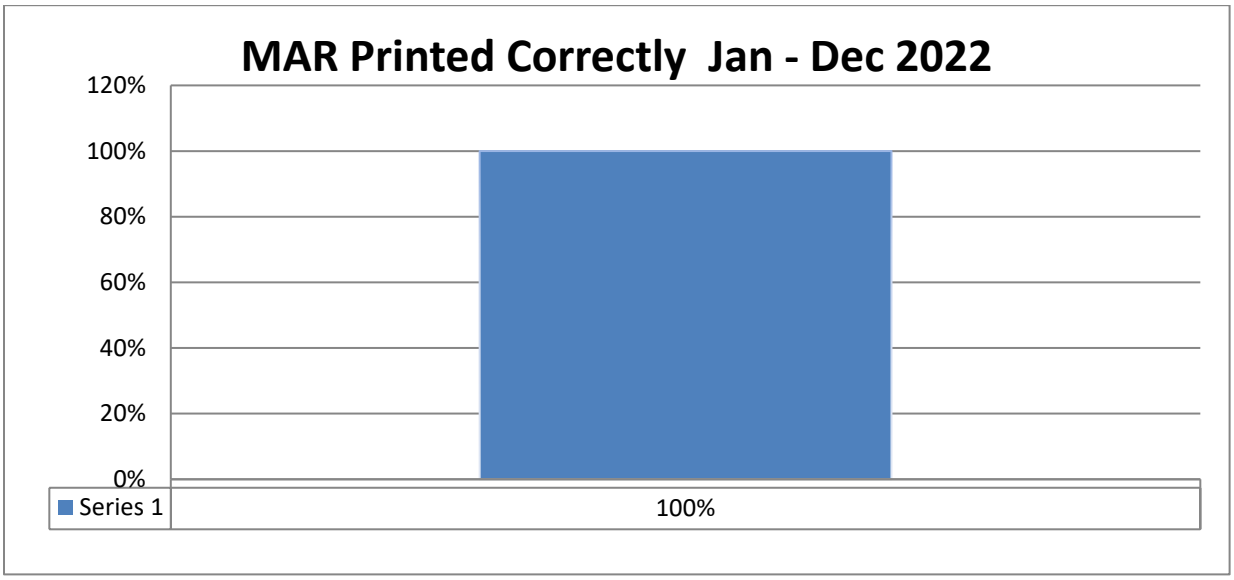
Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, the goal of a less than 3% rate of occurrence of MAR Charting Errors was met, and procedural errors were noted for all four quarters was 0.17 % during 2022.

Plan of Action:
As the goal was met and significant improvements were made compared to the previous calendar years, no changes are planned in maintaining MAR accuracy.



Objective 3: Maintain a 100% rate of MARs being printed with all the required information (including individual's sex, DOB, and delegating Nurse's name)

CSC is partnered with Care one Pharmacy to serve our individuals' medication needs. They continue to increase their involvement in patient care activities provided to communities. Proper and accurate documentation is an absolute necessity to them.



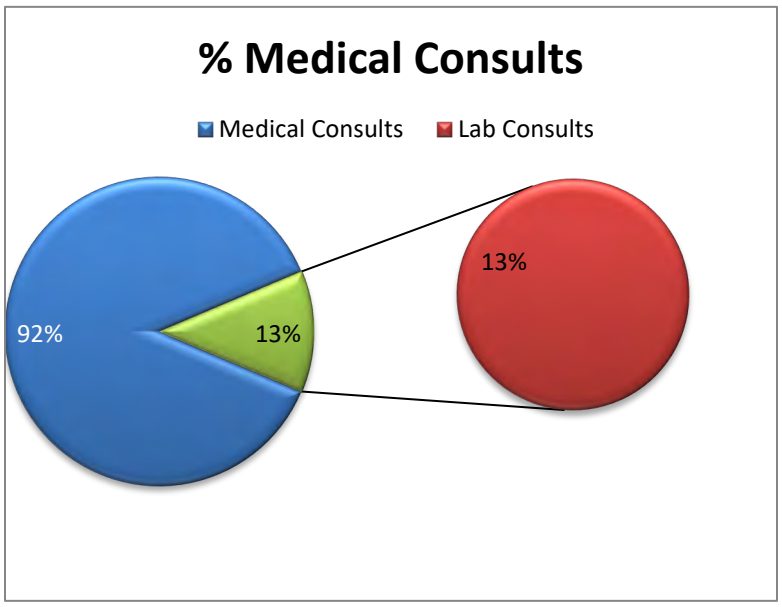
Results/Discussion:

During the reporting period of January 1, 2022, to December 31, 2022, 100% of MARs were printed without errors and with the required information. During 2022, four quarterly audits were completed on random individual medical binders. All four audits completed were on different information such as the person served correct Name, DOB, Gender, Physicians name, Delegating Nurses name, allergies, etc. Audits by clinical and QA staff have been completed and can be located in the QA audit section.

Plan of Action:
The Coordinators and Clinical Department will continue to work with Care one Pharmacy to monitor new printed MARs each month to ensure all required information continues to be reflected. Quality assurance audits will be completed planned or randomly, and an analysis report will be submitted to the Quality Assurance committee.

Objective #4: Achieve a rate of 100% of the completed consult forms to be uploaded in the Therap on line documentation system.

Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, 100% Based on the audit, a total of 3728 completed consult forms were successfully uploaded in Therap. Lab consults were total 543 Total number of consults uploaded in THERAP was 6860.



Plan of Action:

In 2022, our Clinical Specialists' biggest challenge was receiving the completed consultation forms. Clinical staff will continue to process and upload consultation forms completion of each appointment. Our Quality Assurance team will continue to monitor the completion-upload of the consultation form in the Therap online documentation system.

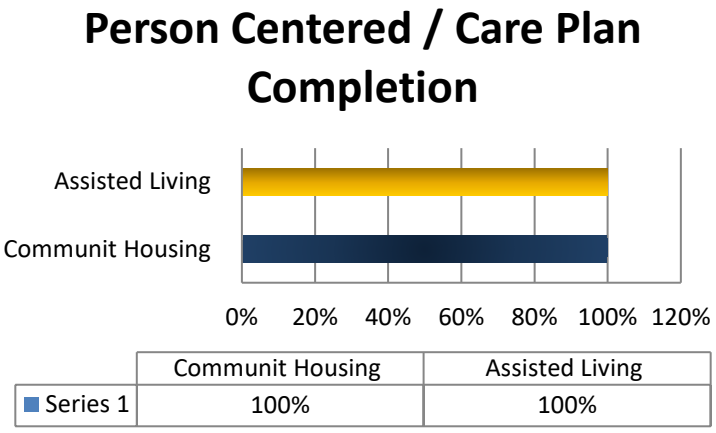
Objective #5: Achieve a rate of 95% in Nursing/Health Case Management and delegation for interim follow up evaluation after hospitalization.

Results/Discussion:

During the reporting period of January 1, 2022, to December 31, 2022, 100% of all emergency room visits/hospitalizations have had completed follow-up by the delegating nurse within 24 hours. In 2022, 93 emergency room visits/hospitalizations required follow-up from the Delegating Nurse.

Objective #6: Achieve 100% of all Person-Centered plan's being up to date in AMDC, Community Housing, Assisted Living, Employment & Vocational Day Habilitation Programs.

The Quality Assurance Coordinator is responsible for gathering the data during Programs meetings where the program specialist reports how many Person-Centered plans are due, completed, or upcoming. In 2022, all Person-Centered plans were audited to determine if the current plan was implemented within the required year from the date of the last plan. A database is kept up to date to identify when the last planning meeting was held and when the next one is due. Program Specialists update that database once the planning meeting has occurred. During the quality assurance monthly meeting the status of the annual meeting is discussed including any delays, or cancelations. The graph below shows the results of that audit:



Results/Discussion:

During the reporting period of January 1, 2022, to December 31, 2022, 187 Individual Plans for community housing and 29 care plans for assisted living were completed by CSC within 365 days. These include the Adult medical day, Employment, Vocational, and day habilitation annual IP. During the QA meeting, the Program specialist provides a monthly schedule for individual plans & Implementation to the QA manager.

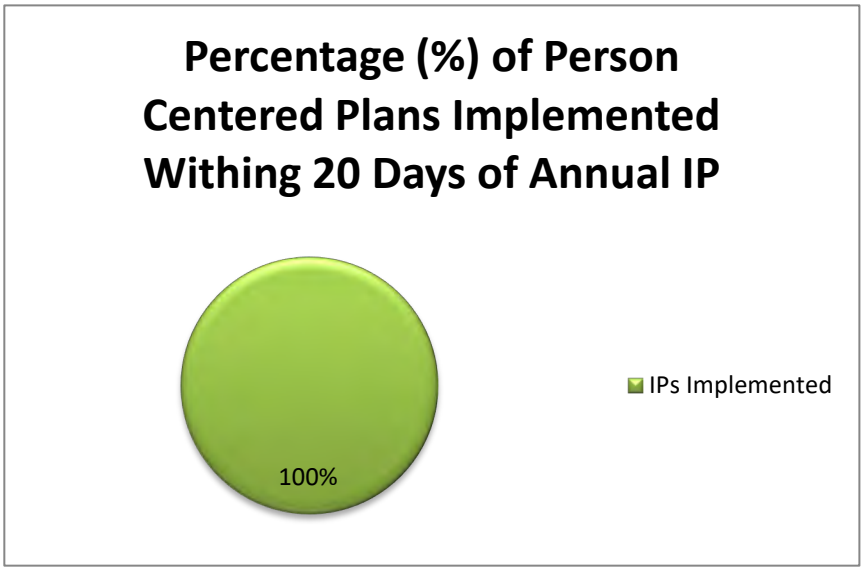
Plan of Action:
The barrier during 2022 was to complete the annual plans on time via teleconferences. Service coordinators needing access to online zoom conferences also was a barrier. The program specialist will continue to hold in-person meetings and use Zoom teleconference to hold Annual IP meetings to ensure meetings continue to be held on time.

Objective #7: Achieve 100% of all Behavior Support Plans being reviewed and updated annually in Community Housing, Employment Vocational, and Day Habilitation services.

Results/Discussion:

During the reporting period of January 1, 2022, to December 31, 2022, 100% of behavior plans were reviewed and uploaded and the goal was met. In preparation for each individual's annual meeting, the Behavior Plan is reviewed with the behavioral data to complete the yearly draft before the meeting to discuss at the annual meeting. One barrier is obtaining the review and signature from court-appointed guardians for implementation, as many meetings are not held in person but instead via teleconference. Of the 187 annual meetings, 71 required behavior plans to be reviewed and updated at the time of the meetings.

Objective #8: Achieve 100% of IP Implementation Within 20 days of annual meeting.



Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, 100% of all IPs were implemented within 20 days of the annual meeting. From a total of 187 individuals, 187 annual person-centered plans were implemented within 20 days of the annual IP, with 0 IP outstanding.

Plan of Action:
One of the barriers identified with children's person-centered plan is receiving signed documentation from the DSS guardians. Program Specialists will continue to schedule the implementation date as soon as the IP date is confirmed with the teams. They will continue to follow up via emails and phone calls to ensure they receive the last IP from the Resource Coordinator within the required time for implementation.

Objective #9: Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare

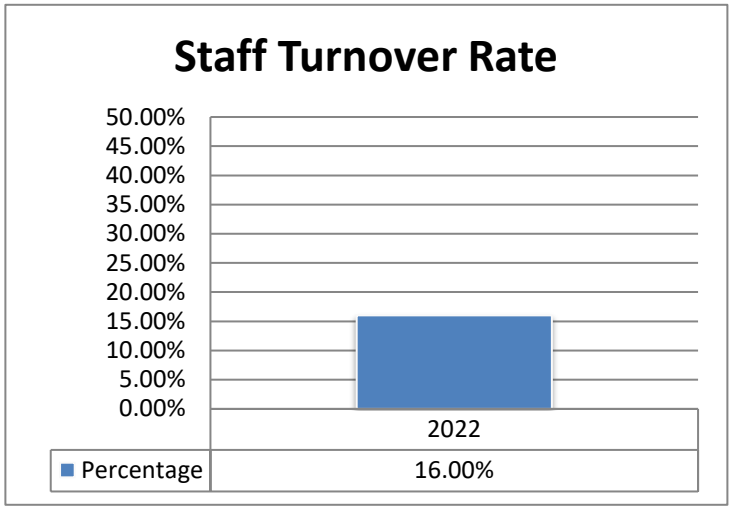
Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, 100% of all care plans were completed and implemented. All care plans were completed and implemented within 10 days. The six-month reviews were completed and implemented within 5 workdays.

Plan of Action:
The Registered Nurse will continue to hold care plan meetings either in person or virtually to ensure all care plans are completed and implemented as required.

Objective #10: Achieve 100% of Person-Centered care plans completed for Rising Sun Assisted living units.

Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, 100% of all Person-Centered care plans were completed. The Assisted Living Units for Center for Social Change provided services for 19 seniors through the waiver for older adults. All care plans were completed and implemented within 10 days. The six-month reviews were completed and implemented within 5 work days.

Objective #11: Maintain a turnover rate of no more than 25% throughout the calendar year 2022



Turnover is defined as anyone leaving the job for any reason, regardless of that staff person's tenure. The turnover rate was determined by identifying the average number of active staff (i.e., received a paycheck) during 2022, how many staff left employment during 2022, and finally calculating the percentage of staff who left employment.

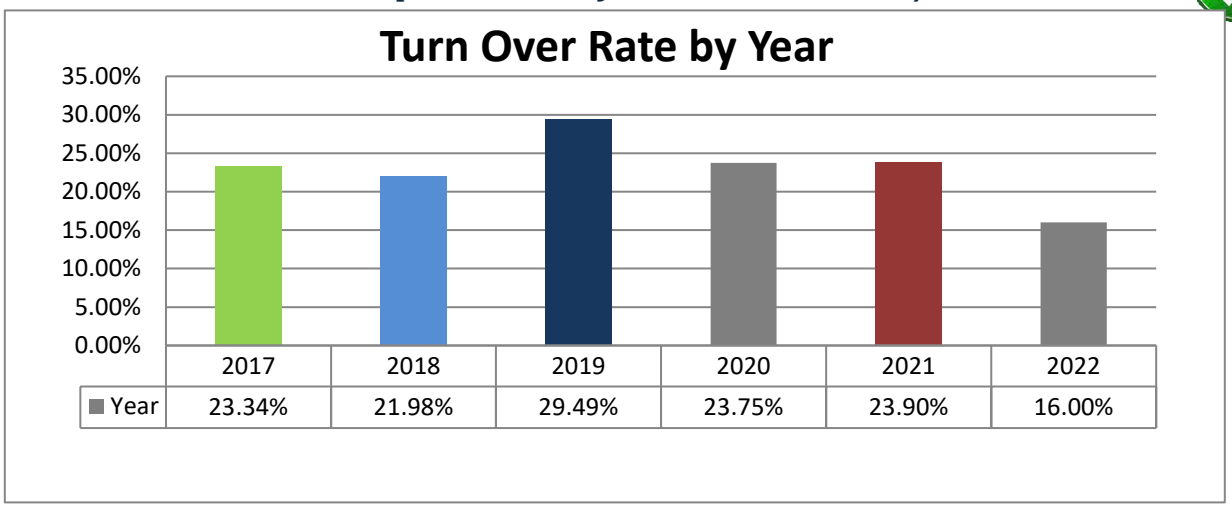
The number of staff personnel that received a paycheck is 486. The number of staff leaving employment during the calendar year was 79.

Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, there was a 16% staff turnover rate. The goal of maintaining a turnover rate of no more than 25% was met by 9%.

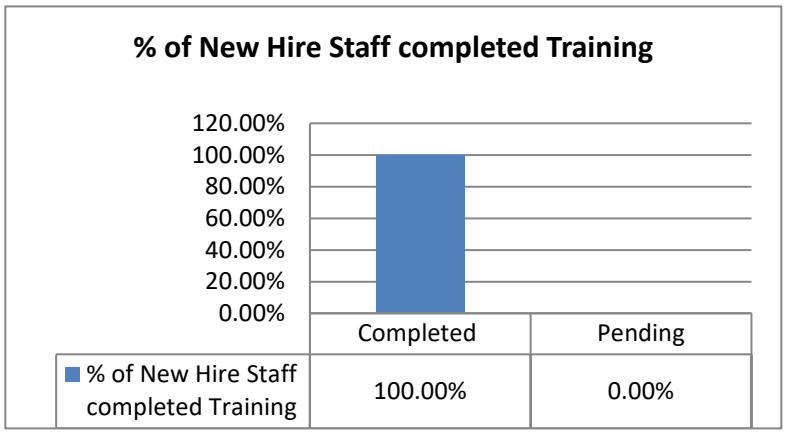
Plan of Action:
The COVID-19 crisis has spotlighted long-term care (LTC) facilities. To address the staffing during the pandemic, CSC took the following actions:
Several incentives were implemented in 2022 to help improve employee morale and retention. Center for Social Change increased all starting wages to minimum wage and offered sign-on bonuses to employees who stayed past probation. After COVID, CSC has also reinstated employee appreciation parties to help boost morale.

Things continuing to affect staff turnover still include employees preferring work-from-home positions, receiving numerous unemployment benefits, and CSC's strict adherence to Awake Overnight Policies. We will continue all of our employee benefits into the new year.

Objective #12: Achieve a completion rate for DDA-mandated/Core trainings 95% for all staff hired during the calendar year 2022

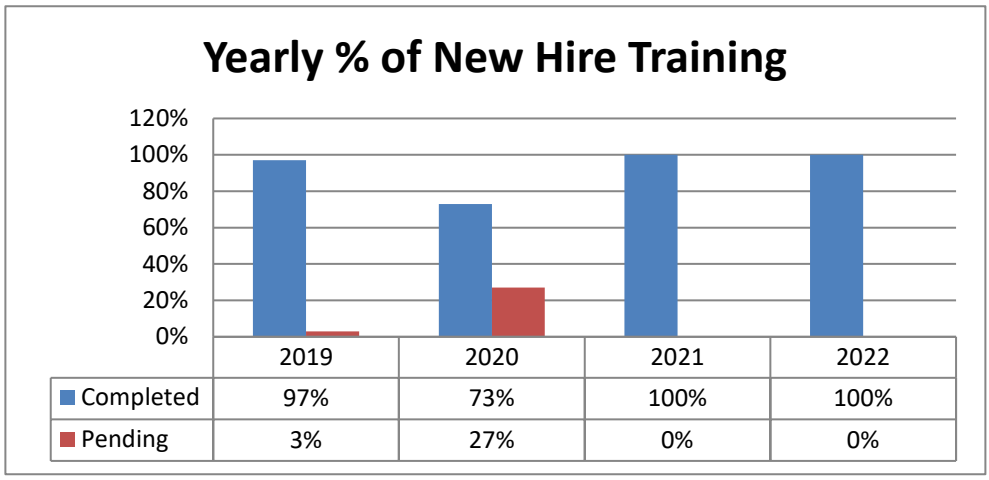


Newly hired staff are required to complete a set of DDA-mandated training within 3 months of their hire date. To determine the percentage of such training which were completed within the required time frame, an audit of HR files was completed to identify those staff who were: a) hired during 2022 and b) who would have been required to complete DDA-mandated training by December 31, 2022.



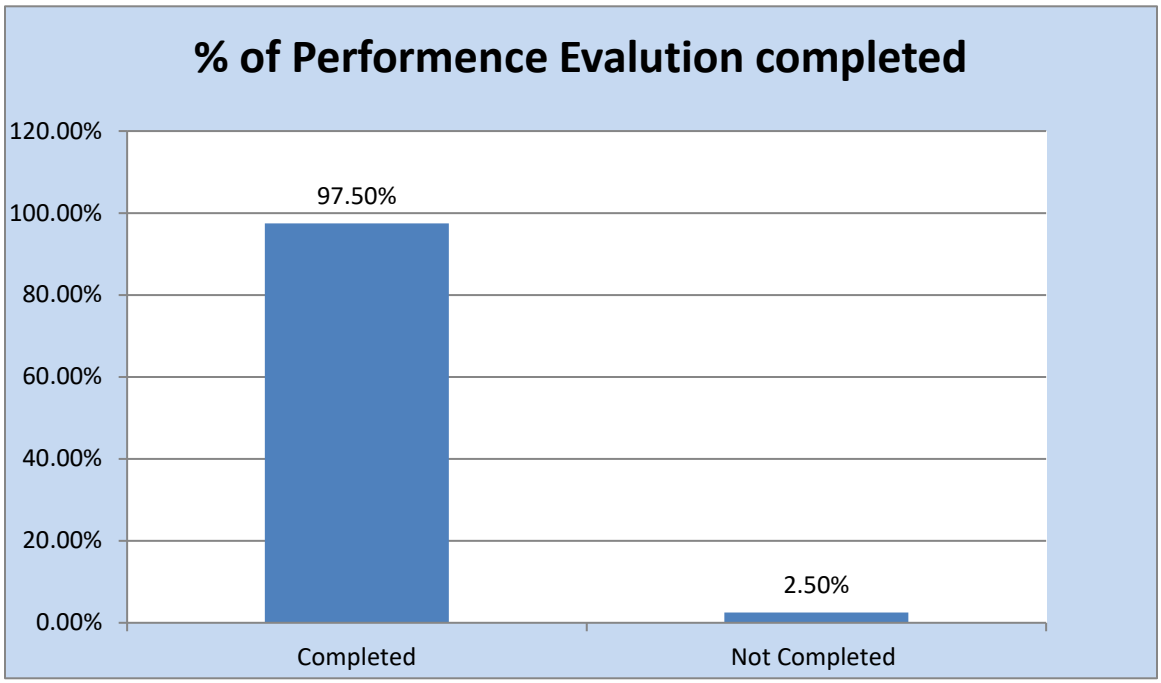
Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, 100% of new hire employees completed all 18 mandated DDA trainings. An audit of calendar year 2022 training files for newly hired staff members revealed that out of the 18 DDA required trainings, the total # of staff with pending trainings is 0. As of December 2022, 21 new hire staff have 90 days to complete their trainings. The primary difficulty in getting all staff trained within 90 days is that many staff has multiple jobs, and scheduling several-day training can be difficult. A Training Coordinator is assigned to generate a report weekly for Coordinators to follow up with staff.

Plan of Action:
CSC will continue to use STED to monitor the completion rate of new hire training. To make some of these trainings easier to access, CSC changed the format of these trainings into easier to consume videos. New hires are able to get the training information in an easy to view and understand format.

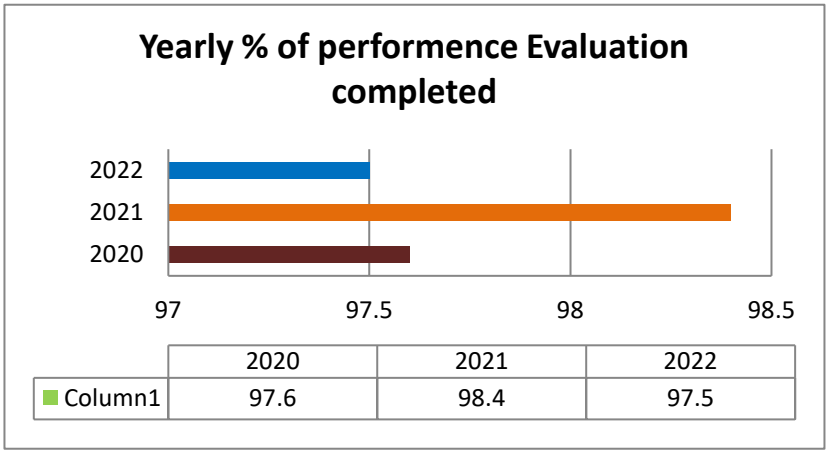


Objective #13:
Achieve and maintain a completion rate of 97 % performance evaluations completed on time

A monthly audit of employee records is conducted to ensure that annual staff personnel performance evaluations are completed on time. Graph, below, shows the results of this audit:



Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, 97.5% of performance evaluations were completed. We met our goal by 2.5%. Of 399 staff, 21 were new hires, and their evaluation is due next year. It is noted that the staff hire date might be different from their actual work start date. For that reason, 30 + or – days are given for the performance evaluation as the staff is completing their training after being hired. At the end of 2022, there were 10 incomplete evaluations.

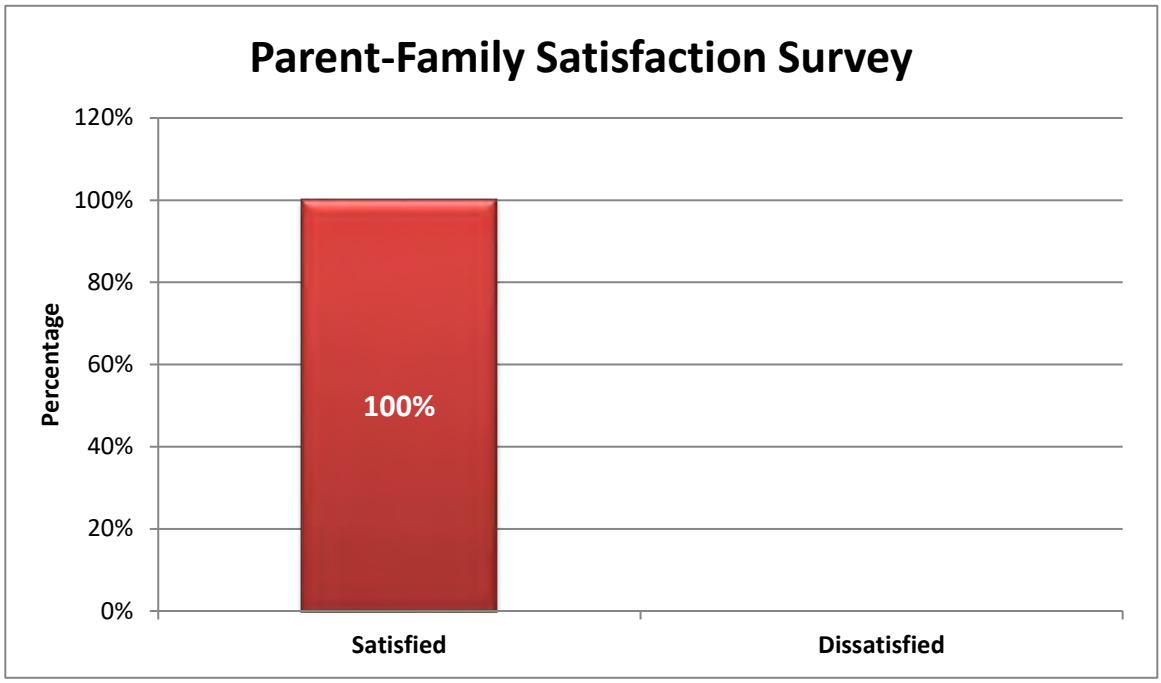


Plan of Action:
One of the barriers identified is that Coordinators are assigned new staff they are unfamiliar with. Another barrier was the delay of paperwork coming to the HR office due to changes in employment and role responsibilities. Moving forward, a list of evaluations due will be provided to all supervisors at the beginning of

each month during the program meeting. Completion of evaluations will be monitored weekly to ensure timelines are continued to be maintained and met. HR staff meets the coordinators during the programs meetings.

Objective # 14: Increase family member satisfaction to at least 95%

In 2022 we tracked the level of satisfaction of Individuals served and their family members (parents, legal guardians, and siblings who are actively involved in the treatment planning of the individual). It was decided to employ the same survey used in previous years for each group so that a comparison could be made between groups. Distribution of family member surveys was done at the Annual IP meeting and during the visits with the individuals.



Results/Discussion:
During the reporting period of January 1, 2022 to December 31, 2022, Parent/Family satisfaction was 100%. One appropriate way to look at all of this data is to determine an "average satisfaction level" among all respondents for all questions. The survey has 10 questions that we use to determine average satisfaction level. We count all positive vs. negative numbers in order to determine satisfaction level.

Total # of Families Surveyed	**6**
Total # of Satisfied Responses	60
Total # of Dissatisfied Responses	0

Plan of Action:

Program specialists and Coordinators are responsible for maintaining contact with family members and guardians weekly. This survey will be repeated in 2023 to compare the averages of 2022. Program Specialists will continue to provide copies of this survey to family members at annual IP meetings to increase participation.

Objective #15: Increase Stakeholder satisfaction to at least 99%

In 2022, we tracked the level of satisfaction of community members and stakeholders. It was decided to employ the same survey used in previous years for each group so that a comparison could be made between groups. Surveys to measure stakeholder satisfaction were prepared and disseminated to the stakeholders in July 2022. We are gathering stakeholder input for Continuous Quality Improvement (CQI). Doing so will enable us to identify areas of satisfaction (or dissatisfaction), allowing us to target these specific areas needing improvement.

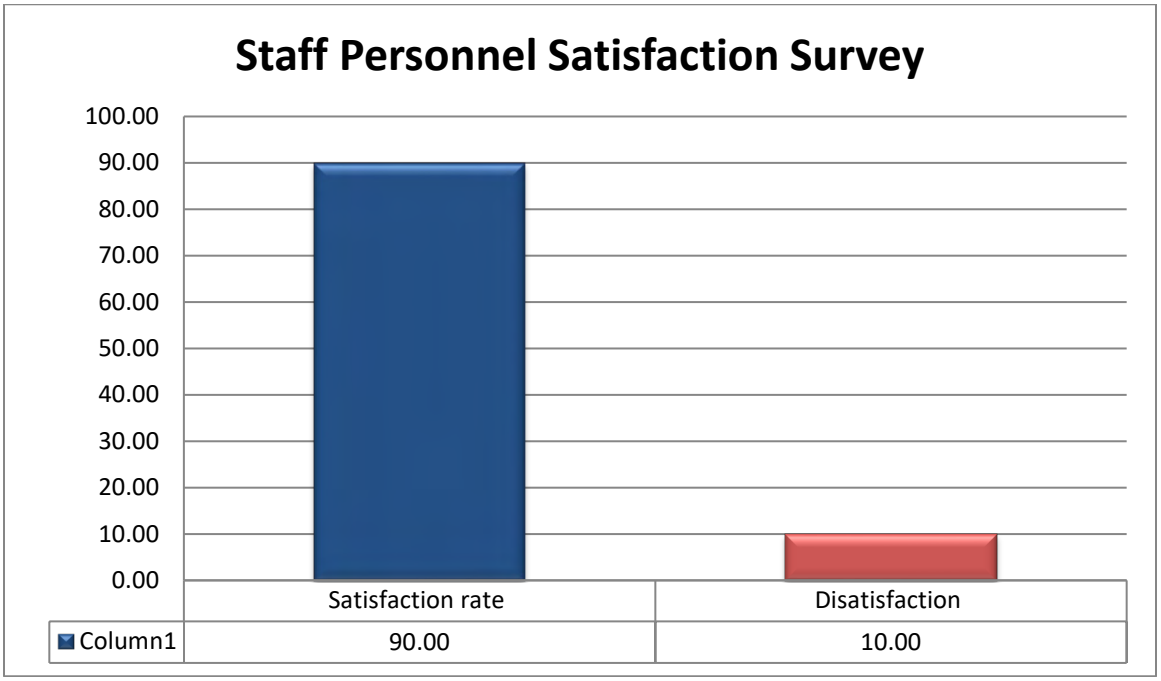
Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, stakeholders responded to surveys with 100% satisfaction. One appropriate way to look at all of this data is to determine an "average satisfaction level" among all respondents for all questions. The survey has 10 questions that we use to determine average satisfaction level. We count all positive vs. negative numbers in order to determine satisfaction level.

Total # of Stakeholders Survey received	**13**
Total # of Satisfied Responses	52
Total # of Dissatisfied Responses	0

Plan of Action:
The highly positive results indicate that no specific Plan of Action is needed. Therefore, the plan will be to continue the processes already in place. CSC will attempt to reach out to more community members, including stakeholders, neighbors, and member organizations, to gather feedback and to increase the number of responses and feedback.

Objective #16: Increase Staff Personnel satisfaction to at least 90%

For 2022 due to the pandemic, it was more important to gather staff personnel feedback. Surveys to measure staff personnel satisfaction were prepared and disseminated to the staff personnel in July 2022.



Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, staff personnel responded with 90% satisfaction. Our goal was not met. One appropriate way to look at all of this data is to determine an "average satisfaction level" among all respondents for all questions. The survey has 10 questions that we use to determine average satisfaction level. We count all positive vs. negative numbers in order to determine satisfaction level.

Total # of Staff personnel Survey Received	**158**
Total # of Satisfied Responses	790
Total # of Dissatisfied Responses	79

Plan of Action:
The results looked at all responses, and only 10 % of all responses displayed dissatisfaction. Most of these resulted from part-time staff not being satisfied with the benefits provided. One of the barriers identified is starting wage, which is very close to the minimum wage. CSC has re-evaluated starting rates as well as existing staff pay rates. CSC has offered a sign-on bonus to attract potential staff personnel and to address the barrier. Many part-time staff is now offered health insurance. HR will continue to reach out to part-time staff to offer full-time positions to such staff before employing outside applicants to provide positions where all benefits can be deliverable to these staff personnel.

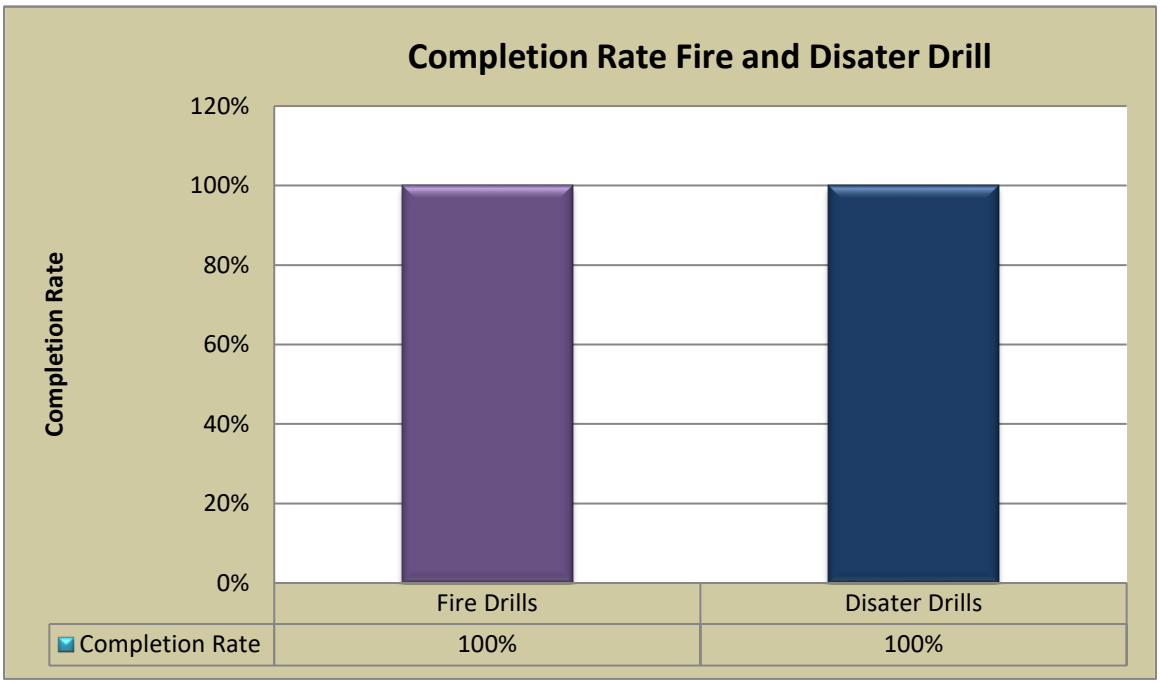
Objective #17: Increase at least 10% in staff personnel Satisfaction survey return rate.

Results/Discussion:
Of the 399 employees in 2022, only 153 returned the satisfaction survey. This is only 38% of staff returning the survey. This has increased by 6% since 2021 but has yet to increase return by at least 10%. The number of staff retained and the longevity of the staff's employment may have led to a slight increase in return.

Plan of Action:
To increase staff satisfaction, starting rates and pay rates for staff employed for 9 or more years have been re-assessed to ensure all are paid competitive rates for the years of service. This will bring about more staff feeling compelled to return a satisfaction survey.

Objective #18: Maintain at least a 100% rate of compliance to the completion of fire and disaster drills

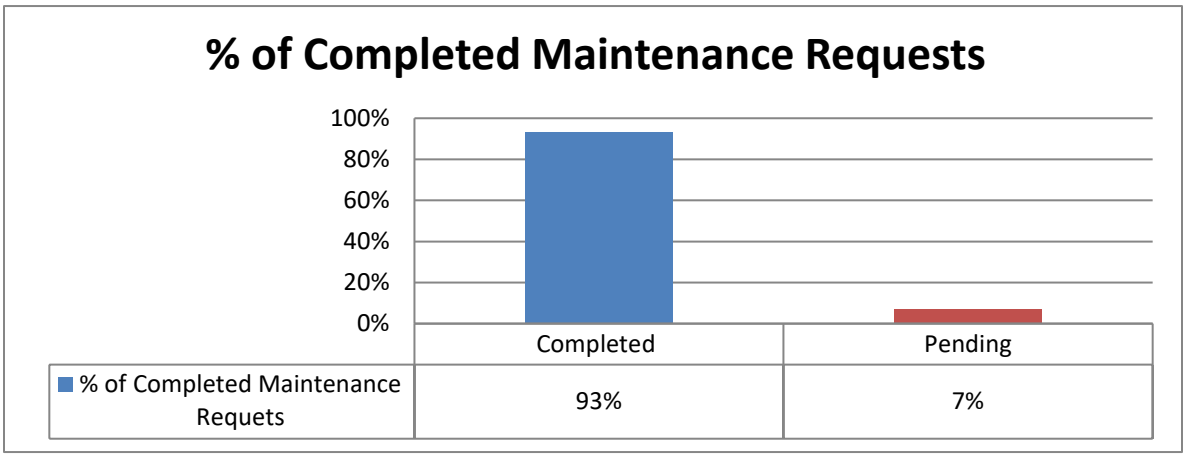
Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, there was a 100% compliance rate for the completion of fire and disaster drills. All fire and disaster drills are completed appropriately as required. CSC has implemented a system to complete a disaster drill (now referred to as an emergency drill) monthly and rotate the shift, as well as utilizing the various emergencies identified in the CSC Emergency Preparedness Plan. Disaster Drills also include Bomb Threat, Utility shut off, violence and natural disasters.



Plan of Action:
A schedule of fire drills will continue to be maintained, ensuring each shift completes such drills throughout the year. Disaster drills will continue to occur monthly. The schedule has been modified to include the violent behavior, Natural disaster; utility shut off and bomb threat for all the shifts. No action plan needed.

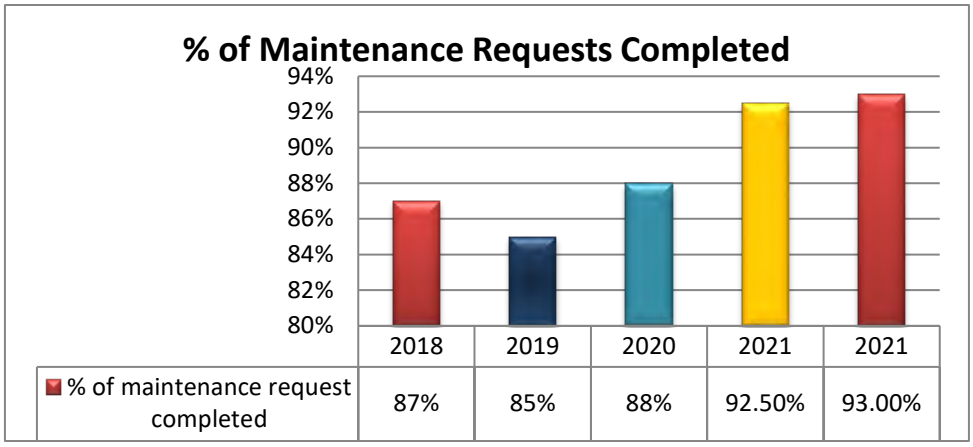
Objective #19: Maintain turnaround of addressing maintenance requests within 24-48 hours with completion rate of 85% during a year.

Center for Social Change currently operates **40** group homes located in the communities of Randallstown, Windsor mill, and the Laurel/Savage area. The maintenance department receives service requests through coordinators and direct staff which are then assigned to other maintenance staff.



Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 20,22, maintenance requests had a turnaround of 24-48 hours with an 87% yearly completion rate. Per the maintenance database, the total number of requests received in the calendar year 2022 was 682, and completed requests within 24-48 hours were 635. Some of the requests were delayed as the staff had to order either new parts for certain appliances or order the items directly from the store. Due to supply chain issues, the wait time to receive items has increased. One of the barriers for our apartment group home locations is reporting maintenance issues to the leasing office for repairs. This process would take much longer for repairs.

Plan of Action:
Staff and coordinators will continue to submit the request to the maintenance department. The maintenance department will continue to work on the request and ensure the database is updated on time. A barrier identified is the lack of maintenance staff to complete the maintenance request. HR is in the process of filling these positions. The graph below shows that the completion rate has increased compared to last year.



Objective #20: Update the Maintenance database with no more than 30 days of entry missing.

Results/Discussion:
During the reporting period of January 1, 2022, to December 31, 2022, the maintenance database was updated with no more than 30 days of missing entries. Per the maintenance database, the total number of requests received in 2022 was 682. It is the responsibility of the Program Manager to enter any noted maintenance request either recommended by a quality assurance home inspection or personal knowledge of any need. Computers in the home and office are equipped to make such entries within one business day. 100% of maintenance requests have been entered into the maintenance database with such time in 2022.

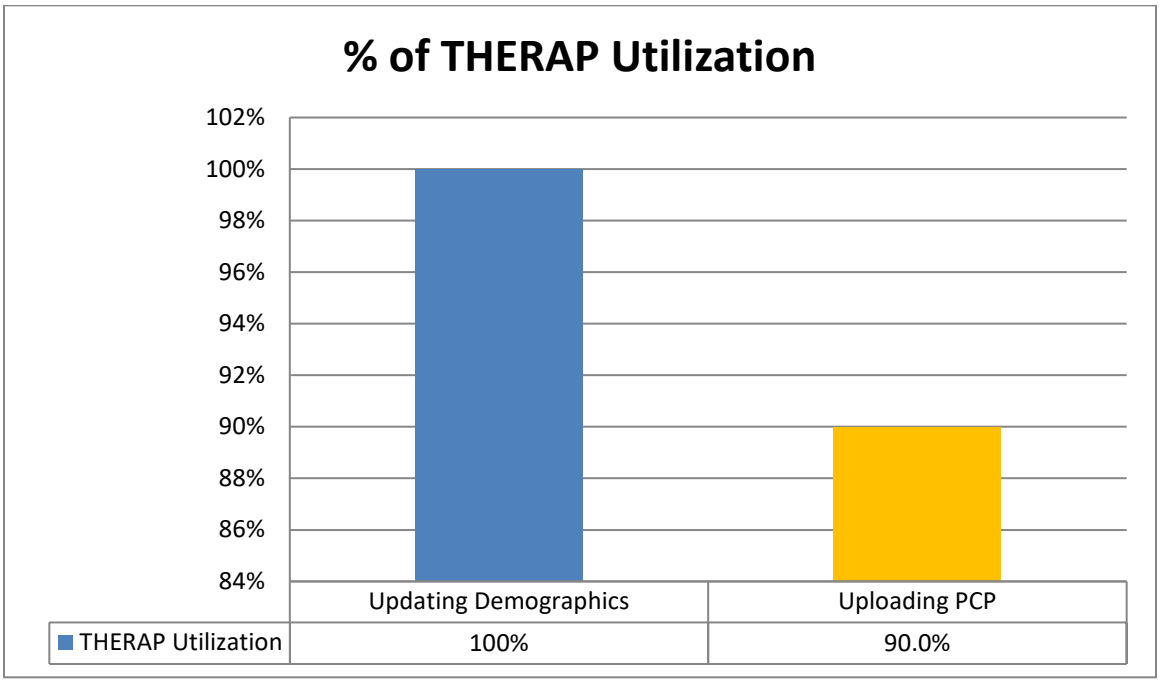
Objective #21 Utilizing STED 100% for all mandated trainings throughout the calendar year 2021

During the reporting period of January 1, 2022, to December 31, 2022, CSC utilized STEDS for 100% of all mandated trainings. STEDS is an in-house software CSC has the flexibility of expanding this system according to CSC's future requirements. All trainings, except for CPR, First Aid, CMT, and MANDT which are in person trainings, are completed by all staff via STEDS.

Plan of Action: Due to the continued unpredictability of global health pandemics, Staff personnel has access to complete the trainings online using STEDS. The goal of utilizing STEDS 100% for all mandated trainings is met.

Objective #22 Utilized THERAP at least 80 % for all people served demographics, IP and outcomes

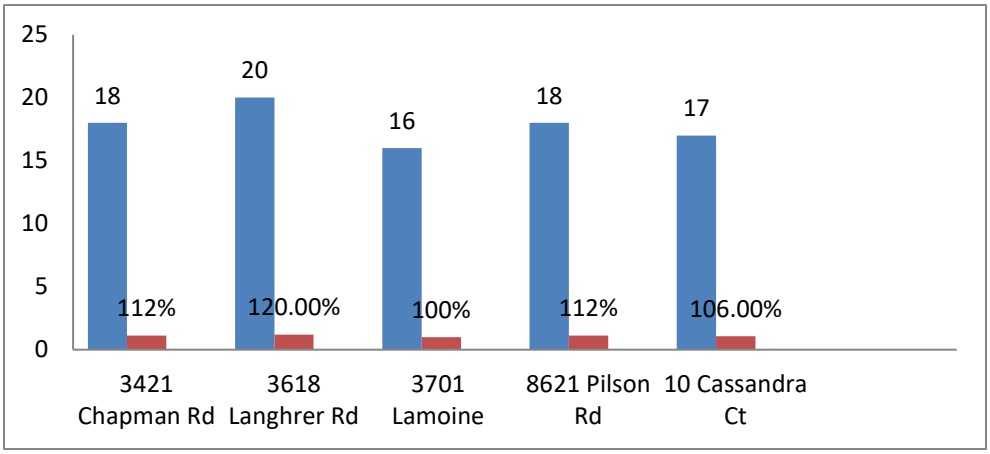
During the reporting period of January 1, 2022 to December 31, 2022, THERAP was used 100% of the time for uploading demographic information and 90% of the time for uploading PCP information. The objective of using Therap was met. As of now staff is capturing the data for demographics on the system as well as IP/BP and progress. Behavioral incidents are documented on THERAP and reports can be generated as needed. Quality assurance staff is also using and updating the demographics and are able to pull reports directly from THERAP. Goal was met for uploading PCP on THERAP.



Plan of Action:
In 2022, we welcomed new program specialists, who were new to the agency and THERAP. They needed some time to learn agency procedures and the functions of the THERAP system.

Objective #23 Utilizing STEDS 85% for ALU meetings minutes

STEDS, the online documentation section (Friday Packet) of the system, has house Meeting Notes – to report each week's house meeting notes to the Program Team. These meeting minutes are used to identify activities and any concerns of the person served. A sample audit was completed for 5 ALUs to check for the completion of ALU meeting minutes. The audit was completed for January, March, July, and October. The minimum number of meetings required for each ALU was 16. Following are the numbers each ALU achieved.



Plan of Action:

During the reporting period of January 1, 2022, to December 31, 2022, STEDS was used 100% of the time for all ALU meetings minutes. Staff personnel has access to completed sample ALU meeting minutes for their homes. It is noted that a few homes are still using paper forms for the individuals that have funds or activity requests, as a signature is required for these items. No action plan is required.

APPENDICES

Appendix A - Resources Used for Data Collection and Analysis

Analysis of Medical/Nursing Services

Therap Online Documentation which contains all information regarding:

- Medical appointments (PCP and specialty)
- Annual physical examinations
- Laboratory workups done
- Hospital/ER visits
- Nutritional evaluations
- Initial nursing assessments
- Nursing Plan of Care
- 45 Day Reviews
- Interim nursing visits (in follow-up to hospital visits)
- The scheduled date for all medical appointments (day/time)
- Whether or not the appointment was successfully kept
- If not kept, reasons why appointments were not kept
- Staff member responsible for ensuring the appointment is kept

Medication Administration Books which contain:

- Current MARs
- Current PMOFs
- Various log sheets (e.g. - blood pressure logs, blood sugar logs, weight logs, seizure logs, etc.)
- Nursing Plan of Care

Analysis of Individual Plans

- Individual Plan/Behavior Plan Database- contains information regarding:
- Start date for IP/BP and for each individual
- Expiration date for IP/BP for each individual
- Required meeting sign-in sheets
- Required individual permission/consent forms
- Copies of IP's and BP's, including goals and Progress Notes
- Implementation dates for IPs

Analysis of staff training

HR Database- contains information regarding:

- Start date for all individual staff
- Documentation of all required personnel information
- Documentation of all required trainings
- Evaluation due date

Training Database- contains information regarding:

- Schedule for all required pending training for all individual staff
- Documentation of completion of all required trainings for all individual staff
- Expiration dates for all required trainings, certification, etc. for all individual staff

Analysis of Incident Reporting:

Incident Reporting Database- containing information regarding:

- Type of incident
- Place of incident
- Date of incident
- Staff involved
- Nature of incident
- Status of A-5/A-7 reporting
- Investigator
- A5 and A7 reports

Analysis of Stakeholder, family, employee Satisfaction:

- Stakeholder Survey
- Parent/Family member Survey
- Employee Survey

Appendix B - Members of Standing Committee

Members of the Standing Committee at CSC are:

Review of BPs

Licensee Staff:

- Dana Dimas, Chief of Programs - Chair
  (dana@centerforsocialchange.org)
  6600 Amberton Drive, Elkridge, MD 21075
  410-579-6789

- Thomas Alexander, Operations Manager
  (thomas@centerforsocialchange.org)
  6600 Amberton Drive, Elkridge, MD 21075
  410-579-6789

Community members:

- John Senyard jsenyard@verizon.net

- Patricia Graham patgraham50@yahoo.com

Review of reportable incidents:
Licensee staff:

- John Dimas, Quality Assurance Coordinator (john@centerforsocialchange.org)

- Thomas Alexander
  Operations Manager, CSC (thomas@centerforsocialchange.org)

Community members:

- John Senyard jsenyard@verizon.net

- Patricia Graham patgraham50@yahoo.com

Alternate member: Sajid Tarar.

The Standing Committee meets at least quarterly**.** During the 2022 calendar year, the Standing Committee met on January 13, 2022; April 14, 2022; July 6, 2022; October 5, 2022.

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